

C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-5747 FAX: (208) 364-1811

August 31, 2007

Ramona Farnsworth, Administrator Desert Rose Retirement Estate, CEC, Inc PO Box 324 Filer, ID 83328

Dear Ms. Farnsworth:

Congratulations to both you and your staff on your recent deficiency-free survey. In today's world with numerous regulations, it is indeed impressive to see a facility functioning as a team at this level.

Continuing to meet the needs of your residents – while meeting the administrative needs of your business – is a daily commitment to quality ongoing assessment, service planning, and consistent provision of services to each and every resident. The greater challenge is, of course, to be able to work as a team to provide this high level of caring and service day after day, week after week, year after year.

Again, Congratulations to you and your staff for a job well done. I challenge you to keep this same high standard.

Sincerely,

JAMIE SIMPSON, MBA, OMRP

Supervisor

Residential Community Care Program

JS/sc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		13R587		B. VVIIVG _		08/2	23/2007
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DESERT ROSE RETIREMENT ESTATE, CEC, II 983 GALLOP DR TWIN FALLS, ID 83301							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE	
R 000	Initial Comments			R 000			
	The residential care found to be in subs Rules for Residenti Facilities in Idaho. I during the standard	V veyor 1SW veyor n, RN	vith the Living cited conducted				
Bureau of Fa	cility Standards						1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE